HIV PREVENTION PROGRAM EVALUATION MATERIALS DATABASE

MATERIALS SELECTION CRITERIA

1.1 Introduction

An effective technology transfer system for HIV prevention program evaluation depends on a number of key issues. Although countless HIV evaluation instruments, books, manuals, journal articles, technical assistance bulletins, and reports have been written since the onset of the HIV/AIDS infection, the lack of awareness of resources, lack of access, and limited range of usefulness of these materials are major impediments to improving HIV prevention program evaluation. To address this void, the Centers for Disease Control and Prevention (CDC) Program Evaluation Research Branch (PERB) created the Prevention Evaluation Technical Assistance System (PETAS) to increase access to HIV evaluation materials. The purpose of this database system is to provide a variety of evaluation resources and consultant references to the following target audiences:

- Community-based organizations (CBOs);
- Community planning groups (CPGs);
- State and local health departments;
- National and regional minority organizations (NRMOs) and other technical assistance (TA) providers;
- Researchers and evaluators; and
- CDC PERB staff.

This electronic database lists and summarizes an array of HIV evaluation materials and also provides pertinent information, such as the type of material, intended audience, evaluation subtopics addressed, publication dates, and authors. Some limitations of the PETAS database include its inability to retrieve materials by target audiences and to provide steps for the evaluation process.[1] As CDC, health departments and other HIV prevention funding streams move toward making receipts of grants contingent on evidence of program effectiveness, the demand for resources such as those found in the PETAS

[1] In addition, materials in PETAS have not been assessed for their ability to discuss or address the barriers to evaluation that many CBOs face when attempting to evaluate their HIV prevention programs.

database is increasing. In addition to the need for evaluation materials, target audiences have also expressed the need for culturally appropriate resources for their organizations including culturally sensitive materials as well as culturally competent technical assistance service providers (Backer et al., 1995; Gibbs et al., 1999; Goldstein et al., 1998; Kalichman, 1998).

To strengthen the PETAS database, CDC further developed the inventory of existing HIV evaluation materials or materials currently in development that can be used by diverse organizations. The task also entailed identifying materials appropriate for use by each target audience, identifying gaps, and recommending ways to translate materials to a different media, format, or level of comprehensibility appropriate to each target audience. To accomplish these tasks, CDC and a contractor developed criteria to assess audience appropriateness of HIV evaluation materials, a system to rate content appropriateness, and a system to categorize materials in the PETAS database by the evaluation steps articulated in CDC's evaluation framework (Milstein, 1999). In addition, materials were assessed in terms of the level of evaluation experience required to comprehend them.

1.2 Material Assessment Criteria

1.2.1 Audience Appropriateness

This criterion was developed to assess the appropriateness of materials for each target audience. To be able to determine audience appropriateness, we made assumptions about each of the six audiences based on our review of the literature and our knowledge of the field. These assumptions and characteristic of each audience are described below and reflected in Tables 1-1 and 1-2.

Community Based Organizations. CBOs are a challenging target audience because they are in varying stages of organizational development and phases of evaluation (Day, 1999). In fact, the National Minority AIDS Council segments CBOs by factors such as the level of organizational development, type of service provided, evaluation requirements of funding sources, and access to evaluation resources.

Table 1-1. Characteristics of Community-based Organizations (CBOs)

Characteristics	Start-Up CBO	Multiple Program CBO	Multilevel Program CBO
Organization	■ Described by their passion and commitment to HIV prevention. ■ Majority of staff may be volunteers.	■ Staff includes full-time professionally trained health educators, salaried and hourly wage workers, and volunteers. ■ May develop attitude of feeling they know "what works" because they have worked with a select population for a few years.	■ Receive funding from numerous organizations. ■ May be national or regional organizations receiving funding directly from CDC, not-for-profit, or for-profit organizations that have partnered with community entities to incorporate HIV into a larger prevention effort. ■ Sometimes plagued by funding constraints, conflicting priorities, and inconsistent messages from the community in need, and an administration that may not embrace the need for rigorous evaluation.
Service	■ Primary focus is dissemination of information, education materials, and/or condoms. ■ Funds are primarily earmarked for outreach efforts. ■ Priority of the organization is to do the job they were paid to do.	■ Often receive funding for more than one issue. ■ Conduct outreach, referral, and treatment services. ■ Passion for prevention exists but is tempered by realities of organization survival (i.e., retaining staff and fluctuating funding cycles).	■ Have been doing HIV prevention for some time. ■ Frequently participate in cooperative agreements with funding source.
Evaluation	■ Very involved with providing HIV prevention services but often lack resources to shift emphasis of program to evaluation. ■ May not have immediate access to someone with program evaluation expertise. ■ May not be required by funding agency to conduct evaluation. ■ Evaluation readiness is usually low.	■ Usually use services of an evaluator when they need help developing a grant proposal and/or evaluation plan. ■ Conduct process- and outcome-based evaluation over the course of 3 –5 year grants they have received. ■ Use epidemiological data collected by staff or local health departments to justify need for prevention services. ■ Often use state-developed instruments to conduct self-report behavioral measurement surveys, pre/post workshop surveys, and focus groups. ■ Tend to create prevention programs with use of evaluation findings. ■ Usually have minimal access to program evaluators.	■ Often required to collect outcome data. ■ Tend to have an internal evaluator on staff.

Source: Evaluation: Maximizing Your Prevention Effort (Day, 1999).

Table 1-2. Characteristics of other target audiences

Characteristics	CPGs	State and Local Health Departments	National Regional Minority Organizations and TA Providers	Evaluators/Researchers	Program Evaluation and Research Branch
Organization	■ In jurisdictions where CDC has cooperative agreements with state, local, or territorial health departments, community planning groups ensure that HIV prevention funding and programs meet the needs of those in their state, county, or territory through an organized community planning process.	■ In jurisdictions where CDC has cooperative agreements with both state and local health departments, health departments are expected to have systems and procedures in place to facilitate coordination and communication between the state and local health departments and their local planning groups.	■ Organizations include national and regional agencies that focus on specific target populations.	■ Evaluators or researchers are often affiliated with universities, or individual or corporate consultant firms. ■ Not always in touch with program-related issues.	■ Branch within CDC's Division of HIV/AIDS Prevention-Intervention Research and Support
Service	■ CPGs implement nine steps of the community planning process that include developing an epidemiologic profile, conducting a needs assessment, assembling a resource inventory, identifying potential strategies and interventions, prioritizing populations and interventions, developing a plan, evaluating the planning process, and updating the plan.	■ State and local health departments usually provide guidelines and funding to implement interventions and evaluation. ■ Primary role is to get CBOs "evaluation ready" by making them feel a part of the evaluation process and familiarizing them with concepts. ■ Health departments must also ensure technical assistance is provided to assist CBOs and CPGs in the areas of program planning, implementation, and evaluation.	■ Committed to ensuring that CBOs receive necessary technical assistance and training to strengthen HIV prevention programs (USDHHS, 1999) ■ Serve as liaison between the funding agency and CBOs, while providing clarification on evaluation procedures. ■ NRMO and other technical assistance providers use technical assistance banks/pools that allocate a set amount of hours for CBO staff to draw upon or they offer a mix of training or one-on-one sessions to provide evaluation assistance.	■ Play an important role in HIV evaluation technology transfer by publishing articles and by making presentations at conferences about HIV program evaluation findings, effective evaluation methods, and instruments for diverse target audience.	■ PERB is responsible for evaluating the national HIV prevention effort by developing the capacity of governmental and non-governmental recipients of HIV prevention funds to collect and use evaluation data. ■ Distributed evaluation materials among PERB's funded technical assistance service providers and health departments.

Table 1-2. Characteristics of other target audiences (continued)

Characteristics	CPGs	State and Local Health Departments	National Regional Minority Organizations	Evaluators/Researchers	Program Evaluation and Research Branch
Evaluation	■ While CPGs are tasked with evaluating themselves through mainly process evaluation indicators, members must be knowledgeable about different types of evaluation (process, outcome, and impact) to assess the success of funded interventions as well as the efforts of the CPG .	■ Because one of the barriers to improving HIV evaluation is the lack of evaluation training, materials that offer strategies to address this problem should be considered appropriate for state and local health departments.	■ Inappropriate teaching methods and greater access to current evaluation technology have been identified as barriers to effective HIV evaluation for NRMOs and other technical assistance providers.	■ A problem confronting researchers/evaluators is the lengthy timeframe for disseminating research results.	■ One of the problems noted for CDC PERB is that there is little or no contact with funded agencies regarding their evaluation results.

Source: CDC Division of HIV/AIDS Prevention/Intervention Research and Support.

Table 1-1 illustrates the organizational, service, and evaluation characteristics of CBOs. This approach classifies organizations into three types of CBOs: Start-up, Multiple Program, and Multilevel (Day, 1999). The most rudimentary CBO is classified as a Start-Up CBO. Generally, these are new organizations that evolve out of a grassroots experience and are run by a few staff and volunteers. Multiple Program CBOs are more experienced than Start-Up CBOs; consequently, these organizations no longer consider themselves the "new kids on the block" and often provide services to address more than one community problem. Funding agencies expect organizations at this level to collect process evaluation data, but demand less outcome evaluation data from them. Multiple Program CBOs often have minimal access to program evaluators. Lastly, the most organizationally developed CBOs are classified as Multilevel because they tend to focus on multiple health and social service-related concerns (alcohol, tobacco and other drugs, violence prevention) and could be implementing as many as 25 projects targeting the same community. CBOs that fall into this category have a lengthy history of HIV prevention and may have an internal evaluator on staff.

While we understand that these three types of CBOs vary in the degree of access they have to evaluation resources and expertise, we have treated CBOs as one group that needs a broad range of HIV prevention evaluation materials at various levels. Thus, when determining whether particular materials were appropriate for CBOs, we included materials that would be appropriate for Start-up, Multiple Program, and Multilevel CBOs.

Community Planning Groups (CPGs). One of the core objectives of CPGs is to ensure that HIV prevention interventions are prioritized based on explicit consideration of priority needs, outcome effectiveness, cost and cost effectiveness, behavioral science theory, and community norms and values. A diverse group of citizens make up CPGs including individuals who are infected with and affected by HIV/AIDS, individuals working for state or local health departments, CBO staff members, and often program evaluators (see Table 1-2). When determining audience appropriateness of materials, we kept in mind that individuals on CPGs have a wide range of experiences with HIV program evaluation. Thus, some CPGs (or individuals on CPGs) may need evaluation materials that describe basic steps in the evaluation process, using terminology that someone without any experience in evaluation could understand, while others evaluate materials that are more sophisticated and describe completed program evaluations including research designs and statistical methods. Again, when we determined whether materials were appropriate for this audience we were inclusive rather than restrictive.

State, Local, and Territorial Health Departments. Like CBOs and CPGs, health departments may employ individuals with a range of experience in evaluation (see Table 1-2). Many health departments have staff whose expertise involves planning, implementing, and monitoring HIV prevention programs, but may have less experience in designing or implementing evaluations and yet have been given the responsibility to do so. Other health departments have trained evaluators on staff who have experience in developing and implementing HIV program evaluations. For this group, we assumed that most health departments were somewhere in the middle; i.e., they have the need for materials that cover evaluation basics as well as materials that describe or use more rigorous designs and methods and require an understanding of basic evaluation terms and concepts.

Technical Assistance Providers, Evaluation Researchers, and PERB. The characteristics of these three groups are reflected in Table 1-2. An assumption we made for these audiences is that staff members affiliated with any of these groups are professionally trained and understand evaluation concepts required to be effective within their respective organizations. When determining whether materials were appropriate for technical assistance providers, we also kept in mind that they often interact with staff who may have little understanding of evaluation. Thus, many "basic" evaluation materials were deemed appropriate for technical assistance providers.

1.2.2 Content Appropriateness

Another criterion used to assess HIV evaluation materials is content appropriateness. Although countless frameworks could be used to assess content, the framework we chose examined the extent to which these materials addressed barriers that impede CBOs from conducting credible and reliable program evaluation. As reflected in a literature review (Rowel et al., 2000) conducted for this project, all target groups face barriers when trying to evaluate programs. Our decision, however, to develop a content rating system for CBOs and not other target groups was based on the following reasons: (1) the small number of barriers cited in our literature review for non-CBO audiences; and (2) with regard to imparting HIV prevention evaluation materials, CBOs are the most challenging of the audiences to reach. For example, evaluation requirements and information for CBOs often are distributed from health departments, technical assistance providers, CDC, or other funding agencies. As a result, CBOs may not seek additional evaluation information outside of these sources. In addition, because CBOs only recently have been required to systematically evaluate their programs, there often is little evaluation expertise

within their staff and thus, it is critical to assess informational barriers to evaluation (i.e., content appropriateness) of materials for this particular audience.

Ten informational barriers cited in the literature review were used to assess content appropriateness. The literature indicates that CBOs are less likely to be effective in evaluating HIV prevention programs when they lack information about:

- Incentives to stimulate evaluation at the CBO, staff, and/or program participant levels (Brown, 1995).
- Strategies to assess their evaluation needs (Gibbs et al., 1999).
- Strategies to conduct culturally appropriate evaluations of programs they implement (USDHHS, 1999).
- Strategies to evaluate programs that target racial/ethnic minority populations that are at-risk for HIV infection (USDHHS, 1999).
- Evaluation designs that take into consideration a wide range of HIV interventions (USDHHS, 1999).
- Strategies to conduct evaluations with limited resources (Gibbs et al., 1999).
- Strategies to teach evaluation concepts and methods that staff and volunteers could understand (Schensul, 1999).
- Language and terms to describe evaluation that would be understood by CBO staff (Backer et al., 1995; Kalichman, 1998).
- Hands-on or easily used materials for CBO staff (Gibbs et al., 1999).
- Easy access to HIV evaluation materials (Gibbs et al., 1999).

To assess content appropriateness, we assessed the extent to which each material addressed these barriers as a way of determining how useful it might be to CBOs.

One additional assessment of content appropriateness was conducted for each item. Each item was reviewed to determine the level of evaluation experience required to understand it (e.g., could a lay person with no evaluation experience understand the terminology and concepts in the material?). Materials were given one of two ratings: (1) prior evaluation experience required, or (2) no prior evaluation experience required.

1.3 Program Evaluation Framework

The last criterion used to assess the appropriateness of HIV evaluation materials is based on program evaluation steps. Several steps are key to implementing effective program evaluation. Enabling users to select materials based on the stage or stages of evaluation on which they are working can be instrumental in helping them plan or implement effective evaluation strategies. Toward this end, the CDC Program Evaluation Framework (Milstein, 1999) identifies six critical steps as depicted in Figure 1-1.

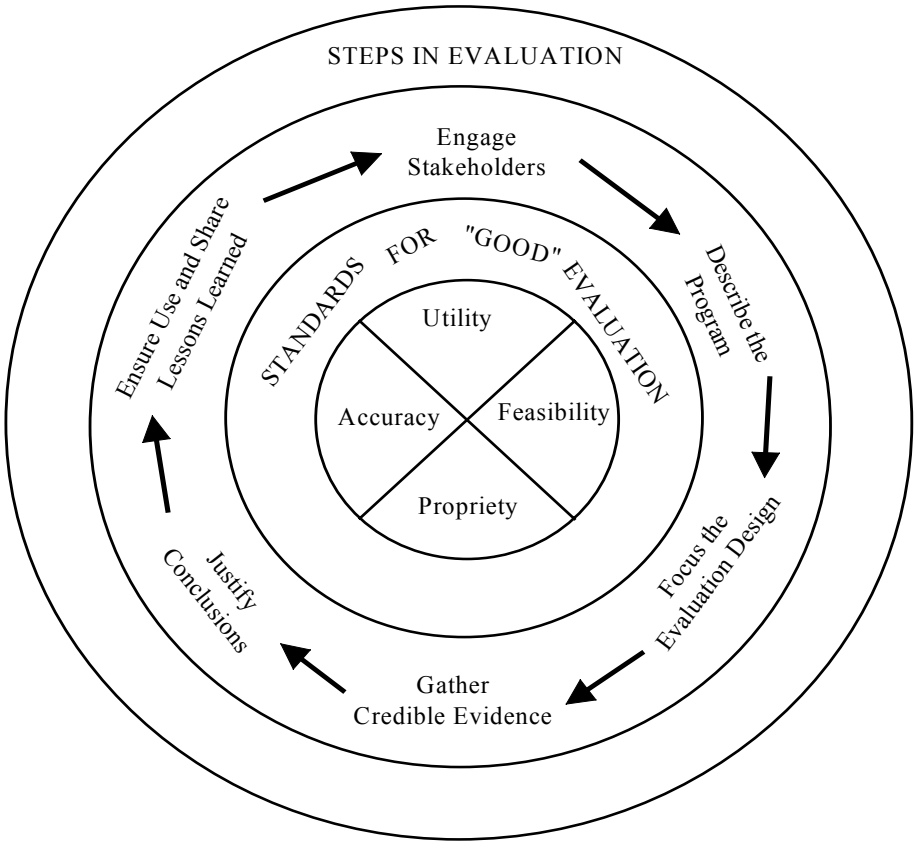

Figure 1-1. Framework for program evaluation

All of these steps were included in the original PETAS database except for engaging stakeholders and ensuring and sharing lessons learned—two steps that are essential to the evaluation process. Engaging stakeholders entails fostering input, participation, and power sharing among those who have a stake in how evaluation is conducted and what will be done with the findings. Ensuring use and sharing of lessons learned while evaluating programs is equally important. This step emphasizes the need to ensure that: (1) certain stakeholders are aware of the evaluation procedures and findings; (2) program

managers and evaluators consider findings when making decisions or initiating actions that affect the program; and (3) participants in the evaluation process benefit from their experience. As a result of adding these two steps to those currently in the PETAS database, all steps listed in the CDC evaluation framework are included. Inclusion of all six evaluation steps will allow for the additional tailoring of HIV evaluation materials to the needs of target audiences.

In summary, modifying the PETAS database so that materials can be categorized based on audience, content appropriateness, steps noted in CDC's Framework for Program Evaluation, and level of evaluation experience required will reduce the time taken by target audiences to identify relevant HIV evaluation materials.

2. METHODS

2.1 Description of Database

The CDC contractor used Microsoft Access 97 to create a database to review HIV evaluation materials. This software was chosen largely because it is a *relational* database whereby relationships are based on key elements such as author, publishing company, or identification number. The use of a relational database eliminates data redundancy and also allows information from several tables to be used simultaneously without combining them. The strongest attribute of Access's relational nature is that it enables the user to make detailed and complex queries on materials in our HIV evaluation database.

The database was created with four tables. These tables are Resource Information, Material Type, Barriers to CBOs, and Evaluation Steps. The Resource Information table contains basic information about the material, such as author, title, publisher, and purpose. This table also includes a field that defines audience appropriateness of material. The Material Type table lists the types of material being reviewed and includes items such as books, journal articles, technical assistance bulletins, and web sites (see Appendix A). This table is known as a "lookup table" in Access and actually is used only to store information. Data regarding material type is actually entered directly into a field within the Resource Information table. The Barriers to CBOs table lists impediments to effective HIV program evaluation. This table was created to evaluate how comprehensive and useful materials are to CBOs; these 10 fields were not part of the original PETAS database. The Evaluation Steps table in PETAS corresponds with the six steps in CDC's Framework for Program Evaluation.

A total of 226 HIV evaluation materials were identified for review. The majority of these materials (67%) were found in PETAS while other non-PETAS materials (33%) were found by conducting an in-depth search. Of the total number of materials identified, 167 were reviewed, analyzed, and discussed. It should be noted that we refer to the combined database of PETAS and non-PETAS materials in this report as PETAS PLUS. Fifty-nine HIV materials from the original PETAS database materials were not reviewed because the authors or sponsoring organizations did not provide the materials to us within the time allotted. Of the materials not reviewed, the majority consisted of evaluation instruments (53%), books (19%), and other materials (28%).

2.2 Materials Review Process

After criteria were developed to assess audience and content appropriateness (barriers, evaluation experience required) and the degree to which PETAS PLUS materials addressed evaluation steps, the senior study director conducted a 2-hour training for the three analysts selected to review materials. A thorough discussion followed to ensure reviewers had a clear understanding of audience characteristics and criteria for assessing materials. For practice, participants were given five HIV materials to review. Upon completion of their review, reviewers discussed coding discrepancies and compared findings. Once reviewers reached a level of comfort and consistency in how they coded materials, they were randomly assigned both PETAS and non-PETAS materials to review. To ensure accurate coding throughout the review process, a senior researcher randomly selected and checked 10 items at the beginning of the review process, 10 at mid-point, and 10 at the end. If a discrepancy was found, reviewers were instructed to check all materials previously reviewed and make necessary changes.

As illustrated in Flow Charts 1 and 2, the process for reviewing non-PETAS and PETAS HIV evaluation materials for audience appropriateness was slightly different (see Appendix B). Prior to assessing audience appropriateness, reviewers assigned non-PETAS materials a temporary identification number that began at 300. Previously assigned identification numbers for PETAS materials remained the same.

Review of Non-PETAS Materials. As with PETAS materials, the title, author, sponsoring organization, publishing company and date, and type of material were recorded for all non-PETAS materials. Using the audience characteristics in Tables 1-1 and 1-2 as a guide, reviewers determined the target audiences for which the materials were appropriate. Particular attention was given to evaluation resources and expertise that were accessible to target audiences. Once the appropriate audiences were selected, reviewers wrote a brief rationale for the selections they made.

Reviewers assessed each material for the level of evaluation experience required to comprehend the concepts, terminology, and information it contained. Each material was given either a rating of “none” or “prior” for the evaluation experience required field.

In addition to examining materials for level of evaluation experience required, reviewers were requested to assess materials for each of the six evaluation steps. A total of 24 related topics were used to make this assessment (see Appendix C).

Reviewers were then asked to determine the extent to which the materials reviewed addressed barriers to HIV evaluation for CBOs. Using the barriers to effective HIV evaluation among CBOs in the previous section, there were 10 questions (barriers) that had YES and NO response categories (see Appendix C).

Review of PETAS Materials. The process for reviewing PETAS materials was slightly different from the review process for non-PETAS materials. As stated earlier, the PETAS database had four of the six evaluation steps, but did not include engaging stakeholders and ensuring use and sharing lessons learned. Consequently, reviewers were instructed to indicate only whether or not material addressed these two missing steps for materials in the original PETAS database. The remaining steps in the PETAS material review process were identical to those described in the review of non-PETAS materials.